SOCIETY OF GENERAL INTERNAL MEDICINE

# SGIM FORUM

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## SGIM Continues Appropriations Battles on Capitol Hill

Lynn Morrison

At the time of this writing (early May), the Congress has just begun work on appropriations for FY 97. Following is a summary of the status of funding for programs important to SGIM members.

### FY 96 APPROPRIATIONS

Final numbers are now available for FY 96 funding levels: the AHCPR was allocated $128 million, 20% below FY 95 funding, and $15.6 million was allocated to the Internal Medicine/Pediatrics Title VII program, $1 million below FY 95. The SGIM has worked hard to save these programs from even more devastating cuts. Initially, in the House-passed bill, a floor amendment had reduced the budget for the AHCPR to $60 million. For HRSA Title VII programs, the Senate committee bill had called for a 20% cut. With the support of Senator Mark Hatfield (R-OR) and Congressman John Edward Porter (R-IL), these programs were saved from these large cuts.

### PRESIDENT'S REQUEST FOR FY 97

In mid-March, the President released his budget proposal for FY 97. Due to the partisan atmosphere on Capitol Hill, few people feel that the President's budget will carry any weight in this year's budget discussions. Nevertheless, the Clinton budget raises some policy concerns requiring the attention of SGIM.

#### Agency for Health Care Policy and Research

The President requests a budget of $144 million for the AHCPR, an $18 million increase over the conference agreement for FY 96. However, the ballooning budget of the Medical Expenditures Panel Survey (MEPS) — previously known as the National Medical Expenditures Survey — consumes all of the proposed increase and then some. A total increase of $30 million for MEPS requires a $12 million cut in funding for investigator-initiated grants. Projections for FY 97 show that this would support 118 noncompeting grants and that the AHCPR would not fund *any* new grants in FY 97 under the Clinton request. The SGIM will recommend a budget of $160 million for FY 97.

#### Title VII Programs of the Health Resources and Services Administration

Again this year, the President's budget proposes to consolidate the health professions program into "clusters" of

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## Match Results, 1996: Reading the Tea Leaves

Mark Linzer, MD

There are exciting and encouraging numbers to be found in this year's NRMP match data: 54% of 14,539 U.S. medical student seniors entered "generalist disciplines," and 2744 U.S. seniors (a 2% increase) chose categorical Internal Medicine (IM). Some other numbers of interest include the following:

- 339 U.S. seniors entered a primary care internal medicine residency, up from 312 last year (an increase of 27 students, or 8%);
- 2276 U.S. seniors entered family practice residencies, up from 2081 last year (an increase of 185 students, or 10%);
- 336 U.S. seniors entered medicine-pediatrics residencies.

The accompanying graph shows that the declining number of U.S. seniors entering categorical IM has leveled off and actually begun to slowly rise. This, of course, is good news. The Task Force published two papers in the early 1990s describing several factors that students said contributed to the decline in interest in IM: the lack of satisfying relations with patients during training, an unsupportive learning climate, a perception

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# Radioactive Sugar

Anne Meneghetti, MD

How do you explain a PET scan in plain English — to your mother, for example? *Well, you take some radioactive sugar, inject it into a vein, and then take pictures….* Much of modern medicine sounds slightly barbaric, if not counter-intuitive, when described in layman's terms. Chemotherapy? Vaccines? Most surgical procedures? Part of my job as a writer of medical policy coverage guidelines entails translating scientific evidence into language everyone can understand. Translation is not the toughest part of this job: finding good scientific evidence upon which to base coverage decisions is.

Who makes final coverage decisions? The public, influenced by highly-publicized lawsuits over coverage denials, likely has a Dickensian view of health plan decision making: a dim, smoky room full of bespectacled actuarials pouring over accounts, conniving a way to squeak out another few dollars for the corporate coffer. Rather the more likely scenario is a group of doctors, excited about the latest and greatest medical advancement, making decisions based upon scientific evidence, and insisting that somebody else in the corporation figure out how to pay for it without cutting anything.

Much of what doctors do has been "grandfathered" into common standards of care; adhered to out of loyalty, tried-and-true experience, or folkloric wisdom. Little has been held to the standards of double-blinded, randomized, controlled clinical trials to assess safety and efficacy, much less cost-effectiveness. However, new drugs, devices, and procedures are carefully evaluated. The criteria used by Blue Cross and Blue Shield Association's Technology Evaluation Center (TEC) are as follows:

- approval by appropriate government regulatory agencies (such as the FDA);
- adequate scientific evidence to permit conclusions about health outcomes;
- net health outcome is improved, and the new technology is…;
- at least as beneficial as established alternatives;
- outcomes are attainable outside research settings.

TEC performs technology assessment not only for Blue Cross and Blue Shield plans, but also for Kaiser-Permanente and for the government's CHAMPUS organization. Other technology assessment agencies include ECRI, a non-profit "consumer-reports" style organization in Pennsylvania. They, like TEC, perform high-quality meta-analysis of medical literature to assess health outcomes. The Cochrane Collaborative is an international grass-roots organization of volunteers who meta-analyze medical literature on a wide variety of topics. Their work is slated to be available on the

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Residents' and Fellows' Corner

# International Medical Graduates: Boon or Ban?

Matthew Wynia, MD

In its Seventh Report to Congress, the Council on Graduate Medical Education (COGME) has called for reducing Medicare payments to hospitals that train graduates of foreign medical schools.[1] Their argument is that Medicare's current policy of paying hospitals, on average, more than $70,000 per resident per year, has been an incentive to overtrain physicians, leading to an impending (or already existing) oversupply and ultimately leading to physician under- or unemployment in the United States. Because most of the U.S. growth in the number of physicians-in-training in the last 20 years has come from an influx of international medical graduates (IMGs), they reason that stifling the importation of such physicians should stem the growing oversupply problem. I believe this leap in reasoning rests on an incomplete understanding of economic forces and that implementation of this recommendation can only hurt American hospitals and patients. Beyond this, unfortunately, the recommendation also taps, perhaps unwittingly, into an ugly undercurrent in the contemporary American political climate.

It is undeniably true that paying hospitals to train residents through Medicare subsidies (some of which do more than just subsidize training, they actually provide a profit for doing so), has induced hospitals to train more residents than are necessary. It is also true that IMGs have flocked to the U.S. to fill training spots as they have been created in response to this financial incentive. What is not clear is that U.S. medical schools, untouched by the COGME report for political and legal reasons, would not leap to fill the void if IMG importation was limited. So far, there has been little demand for increased production of U.S. medical graduates because all of the demand for additional residents created by the Medicare payment incentive has been adequately, rapidly, and inexpensively met by importing IMGs. Should the incentive to train IMGs be removed but the incentive to train American graduates remain unchanged? It would be surprising if the American medical school market, its doors already straining with rejected applicants, couldn't crank out more residents in response. It might take a few years, but U.S. medical schools will turn out as many graduates as the residency market demands. In short, there is little reason to believe that limiting importation of IMGs alone will correct

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President's Column

# The Information Superhighway: In the Acceleration Lane, or a Bug on the Windshield?

William M. Tierney, MD

There is no question that we are on the brink of a fundamental change in the fabric of life in developed countries. Most of us now have telephones and broadcast television sets. Cable television, cellular phones, and electronic mail have become increasingly prevalent. With the accelerating speed of technologic developments and their concomitant down-pricing, one can expect these to be standard accouterments of our lives soon. However, I believe that the very ways that we work, play, and interact with others will change fundamentally when the cable now bringing television into your house (note: I said *your* house; we don't have cable, much to the distress of my kids) hard-wires you to the Internet. We will no longer go to video stores or music stores or libraries — we will simply "check these things out" on the Net. We will do most of our telephoning on the Net, using high-speed and high resolution videophones. It will make no difference where you work, because the platform for your work will be on the Net. Many of us, especially those of us in fields with heavy reliance on communications, will make a substantial portion of our incomes charging for services that now don't even exist.

SGIM is slowly making its way onto this rapidly moving landscape. Two years ago, Eric Larson established electronic mail as the primary medium for communication among Council members. Prior to this, there was little communication outside of the monthly telephone calls and letters. Suddenly, positions could be forged and strategies planned throughout the month via e-mail in just a few minutes per day for each Council member.

In the waning months of Wendy Levinson's presidency, she initiated the SGIM Council's list-server. A list-server is merely a list of other e-mail addresses. When one sends a message to the Council list-server, it goes to each member of the Council. A reply to this message likewise goes to each member of the Council. In this way, the Net became a bulletin board on which conversations between Council members that have broad interest could be viewed, and perhaps commented on, by other members of the

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SGIM Forum seeks to provide a forum for information and opinions of interest to SGIM members and to general internists and those engaged in the study, teaching, or operation for the practice of general internal medicine. Unless so indicated, articles do not represent official positions or endorsement by SGIM. Rather, articles are chosen for their potential to inform, expand, and challenge readers' opinions.

SGIM Forum welcomes submissions from its readers and others. Communication with the Editorial Coordinator will assist the author in directing a piece to the editor to whom its content is most appropriate.

## Fresh Quotes from the Career Choice Task Force

Co-Editors: Mark Linzer, MD
Julia E. McMurray, MD
Mark Schwartz, MD

*"Exposure to underserved populations and my role as a primary care giver in my continuity clinic have been the major factors in my choice of General Internal Medicine as a career."*

*Commentary by John Noble, MD, Chief, General Internal Medicine, Boston City Hospital:*

It was 1957, the uprising in Budapest had been brutally suppressed. Inequity and suppression were also occurring here in America. I decided that if I was accepted to medical school, I would serve where the need was great; in the medical equivalent of "harm's way."

At the Massachusetts General Hospital, it was a privilege to learn from renowned teachers in the mid-1960s. To meet patients who had known my grandfather, my father, and members of my family who have long been living in this part of the country. Other than medical problem solving, however, this did not fit my notion of a practice serving people in need.

Siler City, NC, was a community of 3000 in 1974. Sam Putnam, Ed Dismuke, and I took over a vacated practice with Corrine Klaiman, our nurse practitioner. It was a real-world, rural-community practice. No question, our patients needed us. Most of them had lived in the rural Piedmont for eight generations, farming and working more recently in textile and mill businesses. Caucasian and African-American, they reflected the traditional values of rural and old-time America. They were wonderful people; like my patients at MGH, but in a different setting and in greater need for care.

In 1978, at the Adult Walk-In Clinic and Primary Care Center of Boston City Hospital, I was recruited to establish a Section of General Internal Medicine. My patients are the newest generation in Boston's history; African-Americans, Haitians, Cape Verdeans, Irish, and Italian-Americans — even an occasional Yankee. Their families, their problems, and wonderfully, their successes, have been challenging and rewarding for me. Their medical needs are undeniably great due to neglect, undiagnosed illness, and living in high-risk, stressful environments. Among the children and grandchildren of my inner-city patients, the number of college graduates exceeds the number in trouble with drugs, HIV, or the law. Their relations, loyalties, and determination to succeed, though underappreciated in this tabloid world, are a source of quiet inspiration and their need for care is very great. This is the place I have chosen to practice as a general internist.

*Editorial comment for the Task Force by Mark Schwartz, MD, Dept. of Medicine, Gouverneur Hospital, New York, NY:*

The need for well-trained generalists is most acute for the care of urban and rural underserved patients. Dr. Noble has clearly lived his commitment to both of these populations.

As part of our Task Force's ongoing Career Satisfaction Study, we conducted a focus group with doctors caring for urban underserved patients. Our find-

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## The Information Superhighway: In the Acceleration Lane, or a Bug on the Windshield?

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Council. For the president, it is a great way to assess opinions and act on an idea that can't wait until the monthly telephone calls.

In addition to keeping SGIM in the minds of Council members daily, these innovations have changed our communication needs. Before the Net, ideas were passed among all Council members only during the monthly conference calls and the thrice yearly face-to-face meetings. With almost daily communication now, we can rethink our needs and use the conference calls for those items and issues that require *conversation*, not just opinions. And the meetings can deal with those issues when face-to-face, lengthy conversations, and/or consensus are needed.

For example, at the last two summer Council retreats, there were formal processes of strategy planning with professional facilitators. The results were the Strategic Plan (developed at the 1994 summer meeting) and the Clinician-Educator Initiative (developed at the 1995 summer meeting). These activities focused the Council's subsequent deliberations at meetings and on conference calls. As a result of these rapid and continuous communications among Council members, SGIM can more quickly and competently respond to sudden needs, such as the federal budgetary mess and its threats to Title VII and AHCPR's funding.

Change, however, isn't always easy. The director of another national organization, of about 40 prominent scholars, asked me to set up a list-server for them. They had maintained this organization for years, but there was some dissatisfaction among the staff at the low level of interaction among the members. It was hoped that the list-server would stimulate ongoing conversations among the junior and senior members of this organization. Therefore, I had one of our programmers create their list-server. Late one afternoon, he sent me a message saying the list-server was ready to use, so I sent a message to the list-server (and hence the members of this elite organization) introducing the new technology, describing how it works and how it is supposed to generate dialogue that one could participate in, observe, or ignore. I also said that I would monitor the traffic over the next week or so to see if there were any problems.

There were problems. One of the members was on sabbatical and had set up her e-mail system so that, whenever she received an e-mail message, the system would automatically send a reply to the original author. The reply message stated that she was out town and listed here secretary's telephone number. In

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# Endnotes

Victor A. Bressler, MD

The venues of primary care general internal medicine continue in flux. Declarations that foreshadowed subspecialty erosion are being fulfilled in the marketplace that now drives academic planning towards an accommodation.[1] The anointment of the physician "gatekeeper" by the managed care industry predicts alterations in the design, image, and performance of health care provider interfacing. Questions remain regarding who will be doing what, to whom, for which reasons, to what ends, at what cost, and under whose direction? Voices of the misoneist and the reformer are raised in cacophonous refrain.

The blender from which answers will be concocted has been sloppily spinning for decades, receiving into its vortex a mix of flotsam that now includes family practitioners, general internists, nurse practitioners, physician assistants, internal medicine subspecialists (soon to be reincarnated as subspecialist clinicians), subspecialist investigators/basic scientists, and subspecialist clinical investigators,[2] and the vast array of alternative disciplines that annually capture more patient encounters than all of the rest.[3] There is still more work to be done in the kitchen.

Realigning medical education to the task is a work-in-progress. The acknowledgment that many academic programs are "marginal" should perhaps be restated to include "most, if not all," given the complexities at hand. But then, this is the nature of change. Whether or not medicine has entered into first- or second-order change, the latter projecting that nothing will ever be the same again, is conjecture that time or another essay can address. I prefer to consider that existing resources are abundant, talent is hardly wanting, and values are immutable. Not bad for starters.

My favorite resource is in my home town; a small community hospital that is getting smaller from "down-sizing" like everywhere else. About to celebrate its centennial year — most of that century committed to graduate medical education with a succession of university af-

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## Match Results, 1996: Reading the Tea Leaves

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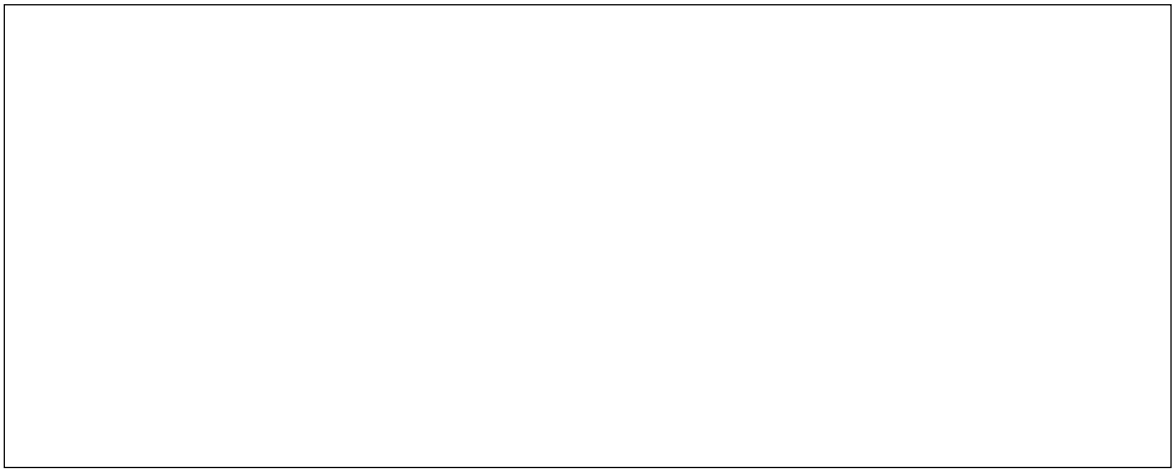

**Figure 1.** The accompanying data is provided by the National Resident Matching Program. Any and all references to these statistics must be credited to the NRMP. From the *APDIM Newsletter*, March 1996.

of excess stress and workload for IM residents and practitioners, and a concern that there was less income and prestige in IM.

Many of these issues have been addressed in meaningful ways by leaders in IM. With perhaps less change in the content than the process of training in IM, we have made IM and primary care IM more attractive career choices. Furthermore, rapidly changing market forces have favored primary care. The number of students choosing IM careers may reflect these issues.

The accompanying graph shows that the majority of the rise in interest in generalist careers is represented by students choosing family medicine. Now we get down to the content issue: a paper by the Federal Council of IM (FCIM) published 3 years ago that defined an agenda for IM "to generate more generalists"[1]; a recent article by Rivo and Kindig[2] demonstrating a marked excess of subspecialists and the possibility of subspecialist unemployment looking well into the year 2020. What remains to be seen is how strongly IM as a profession will continue to embrace generalism and remodel the content of training programs to educate residents in primary care, thus encouraging residents to choose primary care careers.

The 54% "generalist discipline" figure above (that is, the proportion of U.S. graduates choosing medicine, family medicine, or pediatrics) is deceptive, since many graduates choosing IM or pediatrics will eventually subspecialize. Dr. Heidi Nelson, a member of the Task Force, and colleagues at Oregon Health Sciences University have just completed a Robert Wood Johnson Foundation-funded national survey of IM residents assessing factors that encourage them to

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# Mountain West Regional Meeting Held

The sixth annual meeting of the Mountain West Region, the Mountain West Computer Rodeo, was held in Santa Fe, New Mexico, February 8–10, 1996. The meeting was attended by over 40 physicians and students who enjoyed unseasonably warm weather and the charming Hotel Santa Fe. Our plenary and workshop sessions were led by SGIM President, Dr. William Tierney, of Indiana University; Dr. Robert Wigton, University of Nebraska; Dr. Phil Goodman, University of Nevada-Reno; and Dr. Harry L. Greene, Massachusetts Medical Society. Meeting participants learned to navigate the Information Superhighway, to use computer software to develop educational programs, and to use computer systems for patient care. Workshops allowed hands-on computer experience, and the region's Luddite, Dr. Ann Gateley, finally interacted with a computer. Regional investigators presented research during poster and oral abstract sessions, and we had a fascinating keynote address on complexity theory from Dr. Stuart Kauffman of the Santa Fe Institute.

Regional president, Dr. Phil Goodman, is stepping down early to take sabbatical leave in Switzerland to study the ultimate neural network—the human brain. Dr. Robert Raschke of Good Samaritan Regional Medical Center in Phoenix was elected to a two-year term as regional president. Our teaching award went to Dr. Jack Peirce, also from Good Samaritan, for his outstanding clinical teaching skills and research mentorship. Next year's meeting will be held in early February in Breckenridge, Colorado, and Dr. Allan Prochazka of the Denver VA Medical Center will chair the meeting. ■

Richard Hoffman, MD, MPH
Chairman, Mountain West SGIM Annual Regional Meeting
Treasurer, Mountain West SGIM Region

## Radioactive Sugar

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World Wide Web this year (http://hiru.mcmaster.ca/COCHRANE).

Why are these national technology assessment groups so important? Because the differing medical policies among health plans make this nation look like a giant patchwork quilt. If a woman with breast cancer moves from California to Massachusetts should a new set of medical coverage guidelines suddenly apply? Regional cuisine — jambalaya in New Orleans, dim-sum in Chinatown, and peach cobbler in Atlanta — are delectable, regional medical coverage guidelines are not.

If every health plan based medical policies upon the most current scientific evidence there would be much less variation. Unfortunately, many plans have based their policies in part upon local "generally accepted" practice standards. The phrase "everybody's doing it" has little role in the formation of evidence-based medical policies today. Experts were long thought to have the final word in defining the vagaries of what is "medically necessary." The problem with experts around the country is that they don't agree. Each expert is biased by his own research, his own clinical experience, and other intangible inputs. Peer-reviewed literature is the only common standard we share.

Medical literature is not perfect. There is a bias towards reporting studies with positive results, and there is an often intolerable time delay between landmark work and its eventual publication. Most published literature is focused upon what *can* be done, not what *should* be done. The phrase "less is more" is not a common theme of new scientific publications as emphasis is often place upon newer, better, faster, more expensive techniques. Little research addresses the cost-effectiveness of new and old treatments.

### Cost of Care

$V = \Delta Q/C$. Fear not, this is not a version of the Fick equation, it's about value. Value is quality over cost. If a treatment results in dramatic improvement, from near-death to complete cure then, even if it is extremely costly, it would be considered very valuable. If a newer, faster, more sensitive scan detects cancer or coronary disease slightly sooner thereby prolonging life by one week, but the scan costs $70,000, its value is low. Quality of life (QOL) is arguably more important than overall survival. Even "disease-free survival" can be filled with miserable, intolerable side effects in some patients. The quality of life is in large part subjective, but as more sophisticated measurement tools are developed, QOL will figure even more prominently into the assessment of net health outcome. Cost-effectiveness in general is not a criteria for coverage by most health plans.

### Investigational Procedures

While the FDA presides over drugs and some devices, procedures are far less regulated. At what point in the evolution of a procedure is a health plan prepared to grant coverage for its members? Imagine the following scenario at an academic medical center:

### Evolution of a New Procedure

1. Did you hear about his crazy new treatment scheme? I hope he doesn't embarrass us all by mentioning it to the outside world.
2. The IRB *agreed* to it? Mark my words, once the first patient dies from this, heads will roll.
3. So what if the first few patients did okay, they probably didn't even need

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## International Medical Graduates: Boon or Ban?

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the oversupply of physicians in the absence of more fundamental reform of the incentive system that has led to the oversupply problem in the first place.

Regardless of this more complicated logic, the arguments to protect American jobs and save American money by limiting imports of IMGs are emotionally powerful. When the nation is tightening its medical belt and coming to believe that it is paying too much to support too many doctors, why should American taxpayers continue to support foreign-born physicians-in-training? Why should American medical students have to compete with foreign graduates for spots in residency training programs? And why should American doctors accept competition from foreign born graduates of American training programs in the ever-tightening job market after residency? Though these questions are quite distinct from the question of physician oversupply, to many, the answer to these latter questions is clear — we shouldn't.

I'm not so sure.

I bumped into a newly-minted attending physician the other day. She was a friend of mine from fellowship training, so I stopped her to ask how the new job was going at the moderately-sized teaching hospital to which she had gone after finishing her training. She loved it. Interesting cases, bright students, and some motivated residents were keeping her enthusiastic about her decision to stay in academic medicine.

*Some* motivated residents? Yes, some. Only some of the residents, she said, were excited to be there, were intelligent, and eager to learn. Knowing she taught in a program in which about half of the residents are graduates of foreign medical schools, I wondered whether there was any correlation between being an IMG and being in the wrong part of the class. I know, for example, that IMGs are more likely to subspecialize than are American graduates, and I suspected that perhaps they were less interested in the complete care of patients. I have also had some experience with IMGs who had enough difficulty with the English language that they were reticent to speak up; I thought this could be interpreted as lack of interest as well. Remarkably, to me, she believed that most of the best residents she was teaching were IMGs. They had been at the tops of their respective classes back home, the cream of the crop overseas, and eager to take advantage of the opportunities they saw of training in America.

I asked her what she thought of COGME's proposal to limit the importation of IMGs and she was taken aback. To her it was obvious that care in her hospital would suffer. Not simply because fewer residents would be available, but more importantly because some of the very best residents there are IMGs. In the end, it was not merely a numbers issue, it was quality.

These arguments surrounding limiting IMG importation should ring some bells. Readers familiar with the rhetoric of Presidential-hopeful Patrick Buchanon and California Governor Pete Wilson will note the similarities between the questions about imported physicians posed above and the arguments these politicians have made regarding importation of cars, electronic equipment, textiles, and numerous other manufactured items. This should not be surprising, because what we are discussing is commonly referred to as protectionism. Unfortunately for America's doctors and its patients, protectionism in medicine will have the same effect as protectionism in any other sector of the economy. Though it is touted as a means to protect American wages and jobs, it has been shown repeatedly to reduce quality, drive up prices, and ultimately fail to

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## Endnotes

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filiations in support — it remains a best-kept secret. Ahead of its time as a pioneer in continuing medical education, and foreign physician training as an experiment in democracy after World War II, it shifted its internal medicine residency emphasis from inpatient to outpatient continuity primary care when the stampede had not yet begun. With "matching," U.S. allopathic schools were virtually closed to recruitment and slots were largely filled by international graduates and a scattering of osteopathic physicians. The right mix of astute selection, faculty dedication, a small resident-to-preceptor ratio, and candidate commitment to achievement harvested higher average scores and first-pass percentages on boards than the U.S. university program average. Fellowship applicants placed well, while entry into primary care practice has steadily increased. The ethnic diversity of trainees has engendered trust amongst the predominantly minority inner-city clinic populations and livened resident interaction. Resident participation in community outreach projects has been enlightening.

The Hospital Board and the community are committed to support Graduate Medical Education. They have responded to the implicit reluctance of Congress and the managed care industry to assure financial subsidy by the creation of a fund dedicated to sustain residency training — and if the doors to medical student recruitment remain closed, there is always the World Wide Web.

All community-based training programs are peripheral, but not necessarily marginal. Their emphasis upon the quality of a continuity ambulatory care experience, close personal precepting, and tangible community-linked disease prevention strategies, indicate that grass roots creative initiatives need not be deferred to evolving national trends in health-care policy. University Departments of Medicine might reap profit for their own programs from the promise of fallow fields sown by health care system change. "Cross sectional didactic learning experiences"[2] integrated with enter-

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quick order, I realized we had a problem. Her system would send the reply to the list-server, which would broadcast it to its members, one of which was she. This new message would initiate another reply, etc. The collision of these two technologies created an infinite loop. Uncharacteristically, I figured this out after only the fourth message and paged my programmer. He didn't answer his page, but the person I did contact assured me that he would arrange to delete the offending name.

When I arrived the next morning there were 268 identical messages in my e-mail folder! Quickly, I deleted them and finally contacted my programmer who deleted the woman on sabbatical from the list-server — but the damage had been done. Over the next day, I received dozens of nasty messages from members of this prestigious organization demanding that I take their names off of this list, that the whole notion of a list-server was offensive. The director of this organization contacted me and said, although she still thought it was a good idea, the list-server would not work for now. I wholeheartedly agreed and killed it.

The take-home lesson here is that no innovation is without its risks and bumpy starts. But this experience has not dissuaded me from taking additional steps to move SGIM more firmly into the information era.

Over the past 12 months, the Council has been working on a means to create an electronic forum for its members. Beginning at the 1995 annual meeting in San Diego, we had made preliminary arrangements to collaborate with Physicians' On-Line, a company that offers free electronic communications to physicians (including e-mail, Medline, medical news, and other medical information resources) in return for displaying advertisements (mostly for pharmaceuticals) on a flashy, animated banner at the bottom of the screen. The advertisements allow Physicians' On-Line to offer both the software and access to the information services at no cost. A number of large national organizations are using Physicians' On-Line as their electronic forum, including the American Society of Internal Medicine, the American Academy of Pediatrics, and the American Medical Student Association. Physicians' On-Line provides these organizations electronic bulletin boards, information storehouses from which items can be downloaded, and more.

The main down-side of Physicians' On-Line has been the speed of system response (it tends to be quite sluggish most of the time) and the responsiveness of the personnel to our inquiries. In the meantime, during discussions at regional meeting, where most of the attendees were already regularly using a Web browser such as Netscape®, we have been persuaded by our members that creating a home page on the World Wide Web would be a smarter and more permanent electronic medium. A number of other organizations within SGIM, e.g., regions and committees, had already established their own home pages, and an SGIM home page could easily contain links to these other sites. As it turns out, Gary Barnas at the Medical College of Wisconsin had already created an SGIM home page! (Take a peak at the following Web address: http://www.intmed.mcw.edu/sgim.html.) It also turns out that creating and maintaining a home page takes much less in terms of system expertise and cost than I had anticipated.

The information focus for my presidency, then, will be creating our Web presence and helping it evolve into a dynamic forum where members of SGIM and others within and outside of the medical community can learn about us. I have created a communications and informatics task force (which may be elevated to committee status later) that will take what we currently have and gradually mold it into the information focus of our Society. If you have any suggestions on how SGIM should proceed, please let me know (preferably by e-mail at: btierney@vax1.iupui.edu). I hope this will be the beginning of the SGIM equivalent of "Mr. Toad's Wild Ride." We should all be excited — but expect some bumps along the way. ■

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prevent unemployment.

What can be done to prevent or correct a physician oversupply? Setting the Medicare reimbursement for GME training to levels that will not induce hospitals to overhire would have the correct effect. The original formula is far outdated, unfair, frankly capricious in some instances, and is now known to be causing problems. The role of physician-extenders, nurse practitioners, and others can be studied and probably expanded in order to replace some of the IMGs who would no longer be hired if overall Medicare reimbursement levels decreased. In addition, expanding programs like the National Health Service Corps, that might help to redistribute physicians to areas of shortage, and avoiding the use of the Geographic Practice Cost Index, which adjusts Medicare reimbursement to actually discourage physicians from practicing in rural and inner-city areas, would also be good ideas. Open discrimination against IMGs, however, will be ineffective and will harm American patients — who deserve the best possible residents and doctors the world has to offer who want to train in the U.S. — and the acceptance of which would reflect poorly on both the logical and emotional state of medicine in the U.S. in the late 20th century. ■

### Reference

1. Council on Graduate Medical Education. Physician workforce funding recommendations for the Department of Health and Human Services' programs: 7th report to Congress and the Health and Human Services Secretary. Rockville, Md.: Health Resources and Services Administration, 1995.

## Match Results, 1996: Reading the Tea Leaves

*(continued from page 5)*

either specialize or remain "undifferentiated generalists." We eagerly await the results of their analysis to see how much influence IM training programs are exerting one way or the other toward generalism or subspecialization. An article soon to be published in the Fresh Quotes column of the *SGIM Forum* will discuss one resident's perspective about how IM residencies continue to highlight subspecialists during training and thus encourage specialization.

If IM wishes to be counted as a part of the "generalist disciplines," we will have to study our own data. What proportion of IM graduates choose primary care practice and *remain* in primary care? Clearly it is more than the 339 who choose primary care IM residencies, and probably includes a minority of categorical residency graduates. In addition, the days when one could graduate from an IM fellowship program in Pulmonary Medicine and then claim that 40% of ones practice is in primary care may be drawing to a close as managed care seeks out "certified" primary care doctors to control the decision making and thus the purse strings of care.

We also need to know why more graduates choose family medicine, or even medicine-pediatrics residencies over primary care IM. Our early survey data suggested that students who wanted a "more humane approach" chose family medicine over IM. Have we succeeded in dispelling the notion that we are less humane than our primary care counterparts? Or was the perception real, and do we need to change ourselves first? Dr. Harry Kimball, President of the American Board of Internal Medicine, in his Occasional Quotes commentary of January, 1996, described the "elitism and arrogance" of IM toward other specialties and said that it had to be changed. Have we changed it yet?

The numbers are encouraging and the era of primary care is certainly upon us, but will IM be a part of that era? The tea leaves don't reveal the answer. ■

### References

1. Federated Council for Internal Medicine. Generating more generalists: an agenda of renewal for internal medicine. Ann Intern Med. 1993;119:1125–9.
2. Rivo ML, Kindig DA. A report card on the physician work force in the United States. New Engl J Med. 1996;334:892–5.

## Radioactive Sugar

*(continued from page 6)*

the procedure in the first place. It'll never hold up to a randomized trial.

4. It *appears* to be effective, but we need to wait some time to assess long-term effects from this potentially beneficial procedure.
5. It makes perfect physiologic sense when you think about it. I actually thought of this idea years ago, but no one listened to me back then.
6. Of course, it's standard of care now. If a member of my family needed this procedure, I would recommend it without hesitation. I shudder to think about the way we used to treat patients.

Ideally, health plans step in between points 5 and 6. Health plans can make important contributions to ongoing clinical trials, thereby facilitating timely answers to pressing clinical questions. While most health plans cover the medical care (physician visits, scans, lab tests) associated with research protocols, many experimental procedures are not covered. Enlisting patients into trials is a time-consuming process, limited largely to major academic institutions. With shrinking government resources and limited private research funding, health plans must make a commitment to clinical research if we want answers to important clinical questions in our lifetime.

I encourage you to examine the evidence (or at least the source) upon which you base your own clinical decisions. Enroll your patients in trials when appropriate. And publish, publish, publish well-designed clinical trials, so that your new technique will not perish from the list of what is covered by health plans. Evidence-based, cost-effective medical policies will protect patients from both under- and overutilization in these times of changing incentives and protect us all from misspending our health care dollars.

*Dr. Meneghetti is the Director of Medical Policy at Blue Cross and Blue Shield of Massachusetts.* ■

## SGIM Continues Appropriations Battles on Capitol Hill

*(continued from page 1)*

grants. The Internal Medicine and Pediatrics Program would be placed in the primary care medicine "cluster" which would be funded at $80 million. This is slightly above the FY 95 conference report level of $79 million and well above the current C.R. level of $74 million. At this time, it is unclear how the monies within the cluster would be allocated. The SGIM will work toward a 4% increase for the Internal Medicine/Pediatrics program regardless of whether funding is provided as a separate line item or part of a cluster grant.

### Possible NIH Role in Funding Health Services Research

Last year, the Senate Labor Committee staff contacted the SGIM about their interest in consolidating NIH and AHCPR programs. The large drop in funding for investigator initiated health services research, the political battles fought on Capitol Hill over clinical practice guidelines, and the diversion of AHCPR funds to the MEPS has led the SGIM to consider this carefully. A small SGIM working group has carefully examined the pros and cons and has concluded that health services research funding might fare better at the National Institutes of Health and would certainly do no worse. Further, the working group concluded that the peer-reviewed investigator-initiated research programs of the AHCPR could be transferred, while the larger contracted or intramural AHCPR programs could remain at the Agency. This was agreed to by the committee with three specific provisions:

- First, health services research must have its own institute or center at the NIH.
- Second, the funding currently allocated for investigator initiated research at the AHCPR would be transferred to this separate institute or center at the NIH.
- Third, the budget of the separate institute or center would be protected by a "bypass authority" allowing budget recommendations to be sent directly to the Secretary of the Department of Health and Human Services.

The Washington Office is working with staff on Capitol Hill to determine the feasibility of this proposal. ■

## Fresh Quotes from the Career Choice Task Force

*(continued from page 4)*

ings confirmed those of Li et al.[1] and resonate with quotations from John Noble's stories. The four themes were: 1) desire to return to one's roots ("my family who have long been living in this part of the county"); 2) desire to provide service to humanity ("a practice serving people in need"); 3) desire for challenge, adversity, and diversity ("the medical equivalent of harm's way"); and 4) need to make a difference ("no question, our patients needed us").

Physicians choosing careers caring for the underserved tend to be hardy individuals. However, they are vulnerable to isolation, disillusionment, and burnout. Coping and administrative strategies need to be developed to overcome these barriers and to sustain careers in such settings. The resident quoted above had rightly made the link between General Internal Medicine and care for the underserved. We hope increasing numbers of young physicians join this resident in following in Dr. Noble's footsteps. ■

### Reference

1. Li L, Williams S, Scammond D. Practicing with the urban underserved: a qualitative analysis of motivations, incentives, and disincentives. Arch Fam Med. 1995;4:124–33.

## Endnotes

*(continued from page 7)*

prising community-based graduate medical education enterprises possess capacity for pragmatic as well as scholarly aspects of training that span the existential vista projected for general internal medicine, as well as the subspecialties.

Generalism, advancing beneath the manifold banners of health-care reform, has captured some high ground. Now, subspecialization is sounding its call to arms. If generalism and specialism in internal medicine are to remain comrades and colleagues, they had better agree to common cause as opposed to waging covert private warfare. Most of the troops who are caring for most of the patients are not entrenched in ivory towers but are watching over their shoulders and waiting, even as their skirmish lines are digging in. ■

### References

1. Weiner, JP. Internal medicine at the crossroads: training subspecialists for the next century. Ann Intern Med. 1996;124:681–2.
2. Langdon LO, Toskas PP, Kimball HR, and the American Board of Internal Medicine Task Force on Subspecialty Internal Medicine. Future roles and training of internal medicine subspecialists. Ann Intern Med. 1996;124:686–91.
3. Eisenberg DM, Kessler RC, Foster C, et al. Unconventional medicine in the United States. Prevalence, costs and patterns of use. N Engl J Med. 1993;328:256–62.

## Classified Ads

Positions Available and Annoucements are $50 for SGIM members and $100 for nonmembers. Checks must accompany all ads. Send your ad, along with the name of the SGIM member sponsoring it, to *SGIM Forum*, Administrative Office, 700 Thirteenth Street, NW, Suite 250, Washington, DC 20005. Ads of more than 50 words will be edited. Unless otherwise indicated, it is assumed that all ads are placed by equal opportunity employers, and that Board-certified internists are being recruited.

PROFESSOR/ASSOCIATE PROFESSOR, DEPARTMENT OF MEDICINE. Associate Professor/Professor (tenured) to head the Division of Health Outcomes Research in the Department of Medicine at the University of Minnesota. Individual to direct outcomes research program with physician and PhD scientists to assist/develop educational materials at all levels in the use of outcomes information to improve medical practice. Outcome studies will address the full range of outcome issues relevant to internal medicine — from prevention through subspecialty practice. The Division will coordinate activities with the university-wide Clinical Outcomes Research Center and VA program and will collaborate with the School of Public Health. Qualifications include: MD, completion of 3-year residency program, board certified in Internal Medicine; Associate Professor — professional distinction in research and writing and demonstrated effectiveness in teaching and advising; Professor — national reputation in research and evidence of leadership in candidate's professional field; eligible for MN license, must qualify for full hospital privileges. Apply by June 30, 1996 to: Gary Francis, MD, Professor of Medicine, University of Minnesota, Box 508, UMHC, 420 Delaware St. SE, Minneapolis, MN 55465. The University of Minnesota is an equal opportunity educator and employer.

POSTDOCTORAL FELLOWSHIP. Recent doctoral degree graduates for one-year postdoctoral fellowship to health services research. May be renewed. Must be a U.S. citizen. Annual salary $34,000. CV to Terri Menke, PhD, Fellowship Program Co-Director, HSR&D Field Program, VAMC-152, 2002 Holcombe Blvd., Houston, TX 77030 by 7/1/96. An equal opportunity employer.

DIRECTOR OF MEDICAL EDUCATION for Medical School Primary Care Department. Responsible for coordination of multidisciplinary primary care educational programs including Physician Assistant, Nurse Practitioner, Medical Student, Medical Residency, and Primary Care Fellowship training. Also includes leadership, mentoring, faculty development, and directing our expanding Primary Care Fellowship Program. Requires MD or PhD with expertise in medical education. Review of applications will begin June 1, and continue until position is filled. Send C.V. and cover letter indicating position HCS 95-08 to: Debbie Eiland, Faculty Recruitment Coordinator, Department of Health Care Sciences, George Washington University, 2150 Pennsylvania Avenue, NW, Room 2B-408, Washington, DC 20037. The George Washington University is an equal opportunity/affirmative action employer.

ACADEMIC GENERAL INTERNIST. The Division of General Internal Medicine of Saint Louis University School of Medicine seeks ABIM certified candidates for faculty positions at the assistant/associate professor level. Responsibilities involve direct patient care in a faculty practice, consultative medicine, and ambulatory and inpatient education of medical students and residents. Programs for scholarly activity are individualized. Contact: Thomas J. Olsen, MD, General Internal Medicine, Saint Louis University Health Sciences Center, 1402 South Grand, 12th floor South, St. Louis, MO 63104-1083. Equal opportunity employer. M/F/H/V.

HEALTH SERVICES RESEARCHER. PhD in economics, psychology, epidemiology, sociology, or a related field required. Experience in multidisciplinary research and first-authorized publications. Salary competitive. Must be a U.S. citizen. CV to Nelda P. Wray, MD, MPH, Director, SHR&DFP, VAMC-152, 2002 Holcombe Blvd., Houston, TX 77030 by 7/22/96. An equal opportunity employer.

HEALTH SERVICES RESEARCH FELLOWSHIP. New England Medical Center's Division of Clinical Care Research has one unexpected opening in their two-year postdoctoral fellowship program with an MPH starting July 1996 for physicians who have completed clinical training. For information contact the office of Harry P. Selker, MD, Chief, New England Medical Center, 750 Washington Street #63, Boston, MA 02111. Call (617) 636-5065 for an application.

GENERAL INTERNAL MEDICINE FELLOWSHIP. The Cleveland Clinic Foundation has positions available for physicians who have completed an accredited residency program and are interested in an innovative fellowship training experience in General Internal Medicine. This two-year program is designed to train future leaders in internal medicine through formal and informal curricula in clinical medicine, research design and quantitative methods, teaching effectiveness, and practice management. Fellows will concentrate in one of the content areas of training and will conduct projects in health services research, medical education, and/or quality improvement with an experienced faculty mentor. The Cleveland Clinic Foundation, affiliated with Ohio State University, offers extensive resources for support including health policy, medical ethics, practice administration and health services research as well as diverse opportunities in clinical medicine. Salaries and benefits are highly competitive with other programs and fellows will be provided support for research projects and attendance at national and regional meetings. For additional information, contact David G. Litaker, MD, MSc, Cleveland Clinic Foundation (A/91), 9500 Euclid Avenue, Cleveland, OH 44195. Telephone (800) 223-2273; E-mail: litaked@cesmtp.ccf.org.

CHIEF, DIVISION OF GENERAL INTERNAL MEDICINE. The Department of Medicine of The Western Pennsylvania Hospital, a successfully tertiary referral community hospital, is seeking a Board Certified general internist with academic experience to head the Division of General Internal Medicine. The division includes 6 full-time faculty and 102 voluntary staff. The hospital is a major teaching affiliate of the University of Pittsburgh with its own independent resident and fellowship programs and laboratory and clinical research facility. Internal medicine residency includes a primary care track and a current HRSA Primary Care Training Grant. Candidates should be capable of demonstrating excellence in teaching and patient care, have the skills and experience to lead a major division, and to provide academic leadership. We offer a competitive salary and an incentive plan. Interested candidates should forward a letter and a copy of their CV to: Herbert S. Diamond, MD, Chairman, Department of Medicine, 4800 Friendship Avenue, Pittsburgh, PA 15224, or call (412) 578-6928.

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